HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12 MED-QUEST DIVISION

CHAPTER 1727

HAWAII HEALTH QUEST

Subchapter 1 General Provisions

Subchapter 2 Freedom of Choice

Subchapter 3 Eligibility

SUBCHAPTER 1

GENERAL PROVISIONS

§17-1727-1 Purpose. This chapter describes Hawaii QUEST, a demonstration project authorized by section 1115 of the Social Security Act. [Eff 08/01/94; am 01/29/96] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1727-2 Definitions. As used in this chapter:

"Benefit year" means the period from the first day of July of one calendar year through June 30 of the following year.

"Capitated rate" means the fixed monthly payment per person paid by the State to a medical, dental, behavioral or catastrophic coverage plan.

"Catastrophic coverage" means the coverage purchased to protect the State when eligible medical costs incurred by recipients exceed a specified dollar threshold which is determined by contractual agreement between the department and the medical plan.

"Co-payment" means a specified dollar amount or percentage of a service charge for which certain enrollees are responsible to pay their health plans or the plans' providers for certain kinds of services, as specified in the contract negotiated between the State and the health plans.

"Date of approval" means the date on which the department completes the administrative process to certify that an individual or a family is eligible for QUEST.

"Effective date of coverage" means the date on which health care services shall be covered by QUEST either through the fee for service reimbursement by the department or its fiscal agent, or through enrollment in a QUEST health plan.

"Effective date of enrollment" means the date as of which a participating health plan is required to provide benefits to an enrollee.

"Emergency medical condition" means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(2) Serious impairment to body functions; or

(3) Serious dysfunction of any bodily organ or part.

"Emergency services" means covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard.

"Enrollee" means an individual who has selected or assigned by the Department to be a member of a participating health plan.

"Family" means an individual or a group of individuals living in the same household, generally consisting of parents and their natural, adoptive, or hanai children under nineteen, grandparents and their grandchildren under nineteen, an adult sibling and his hanai children under nineteen, grandparents and their grandchildren under nineteen, an adult sibling and his or her siblings under nineteen, a married couple and siblings under nineteen of either spouse, an uncle or an aunt and his or her nephews and nieces under nineteen, a married couple and their nephews and nieces under nineteen, a single adult and his or her first cousins under nineteen, married couples and first cousins under nineteen of one of the spouses, any combination of the preceding relationships prefixed with grand, great-grand, great, great-great, half, and step.

"Hanai" means a child who is taken permanently to be reared, educated, and loved by an individual(s) other than natural parents at the time of the child's birth or early childhood. The child is given outright; the natural parents renounce all claims to the child.

"Hawaii QUEST or QUEST" means the demonstration project developed by the department which will deliver medical, dental, and behavioral health services through health plans employing managed care concepts to certain individuals formerly covered by public assistance programs including the Aid to Families with Dependent Children (AFDC) related medical programs, General Assistance (GA), and the State Health Insurance Program (SHIP).

"Managed care" means a method of health care delivery that integrates the financing, administration, and delivery of health services, or a coordinated delivery system made up of pre-established networks of health care providers providing a defined package of benefits under pre-established reimbursement arrangements.

"Non-returning plan" means a health coverage carrier has a current, but no new contract with the department.

"Participating health plan" means a health plan contracted by the State to provide medical, dental, or behavioral health care services, through a managed care system, to individuals who are found eligible to participate in QUEST and have been enrolled in that health plan.

"Personal reserve standard" means the maximum amount of countable assets that may be held by an individual or family while establishing or maintaining eligibility for medical assistance.

"Premium-share" means the capitated rate, to include that of catastrophic coverage, that certain individuals, based on their income, are required to remit to the Department to be eligible to be enrolled in a participating health plan .

"Primary care dentist" means a general dental practitioner or pediatric dentist who is licensed to practice in the State and is contracted by a participating dental plan to assess an enrollee's dental needs and provide services to meet these needs either directly or through a plan's provider network.

"Primary care provider" means a physician or a nurse practitioner who is licensed to practice in the State and is contracted by a participating health plan to assess an enrollee's health care needs and provide services to meet those needs either directly or through the plan's provider network. A primary care provider who is a nurse practitioner shall be a family nurse practitioner, pediatric nurse practitioner, or, if the enrollee is a pregnant women, a nurse midwife.

"Prudent layperson" means one who possesses an average knowledge of health and medicine.

"Prudent layperson standard" refers to the determination of a emergency medical condition based on the judgment of a prudent layperson.

"QUEST" means Hawaii QUEST.

"Service area" means the geographical area defined by zip codes, census tracts, or other geographic subdivisions that is served by a participating health plan as defined in the plan's contract with the Department.

"Spend-down" means the monthly process by which an individual's or family's income in excess of the medically needy standard is applied toward incurred medical expenses until the net income no longer exceeds the medically needy standard resulting in eligibility for medical assistance.

"Standard benefits package" means the minimum benefits and services which must be provided by each participating health plan which is contracted under QUEST. [Eff 08/01/94; am 07/20/95; am 01/29/96; am 03/30/96; am 07/06/99; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-3 (Reserved).

SUBCHAPTER 2

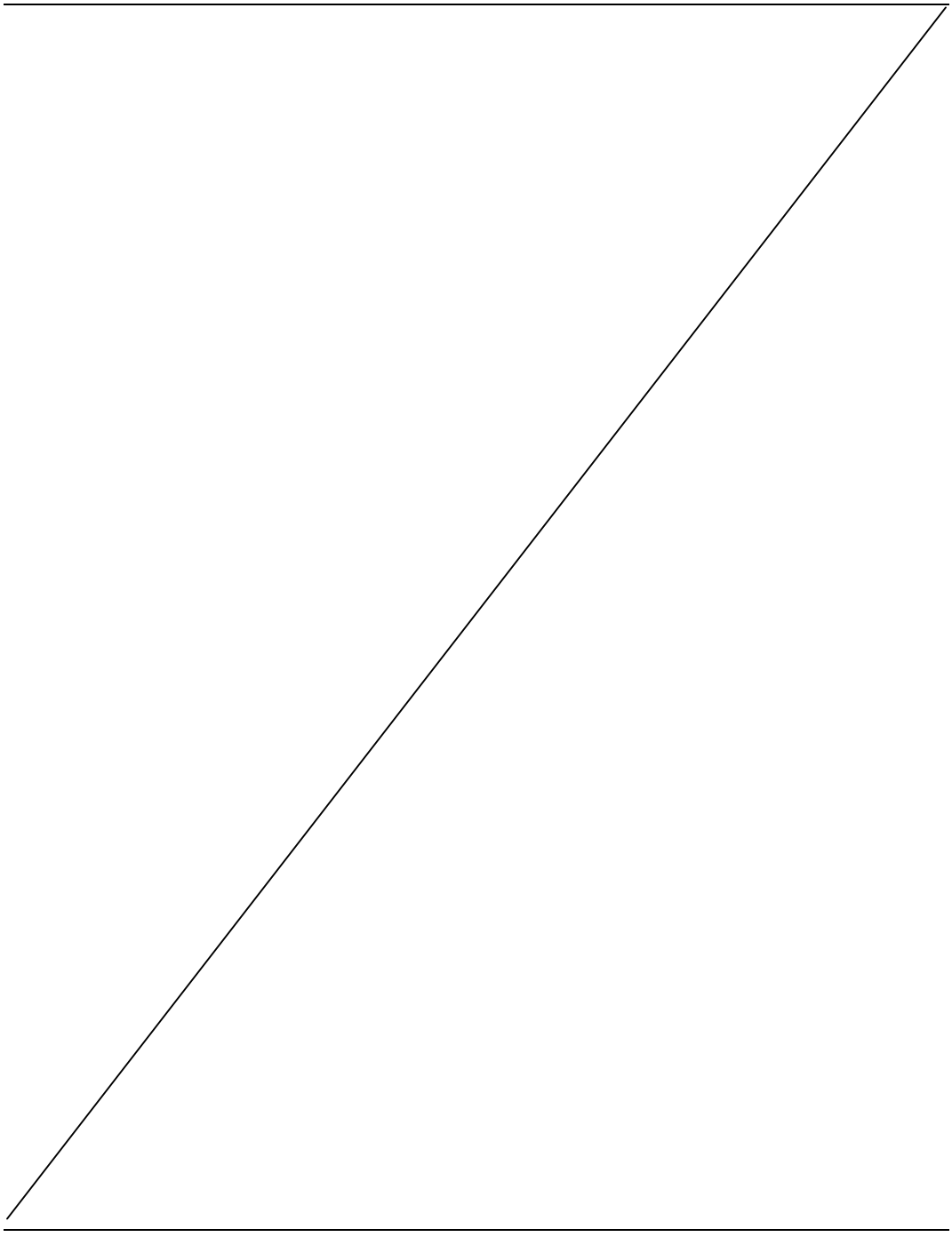
FREEDOM OF CHOICE

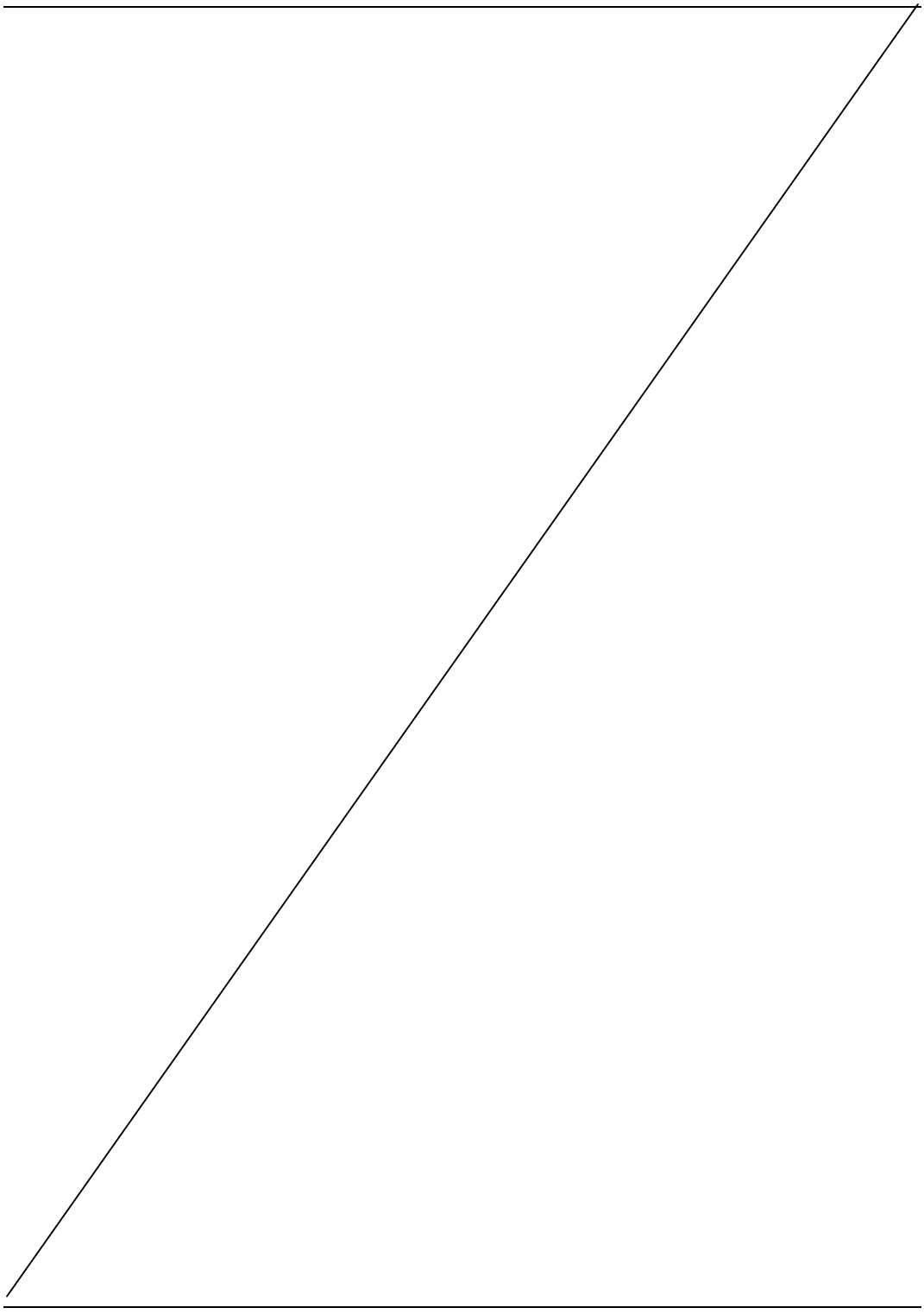
§17-1727-4 Choice of participating health plans. (a) An eligible individual or family shall be allowed to choose from among the participating medical or dental plans which service the geographic area in which the individual or family resides.

(b) All eligible members of a family residing in the same household shall enroll in the same participating medical or dental health plan. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 430.51)

§17-1727-5 Assigned enrollment in participating health plans. (a) An eligible individual or family shall be allowed ten days to select both an available medical and dental plan in which to enroll.

(b) If timely selection among available health care plans is not made, the Department shall assign the enrollment of the individual or family to a health





plan. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-15; 42 C.F.R. §§430.25, 430.51)

§17-1727-6 Choice of primary care provider or primary care dentist. An eligible individual shall be allowed, under the procedures established by the health plan, to select a primary care provider or a primary care dentist from among those available within the plan. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 430.51)

§17-1727-7 Assignment of primary care provider or primary care dentist. If timely selection by an enrollee from among the available primary care providers or primary care dentists within the plan is not made, the plan shall assign the individual's care to a primary care provider or primary care dentist of the plan's choice. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 430.51)

§§17-1727-8 to 17-1727-10 (Reserved).

SUBCHAPTER 3

ELIGIBILITY

§17-1727-11 Purpose. This subchapter describes the eligibility requirements for participation in QUEST and receipt of health care services through participating health plans. [Eff 08/01/94; am 01/29/96] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-12 Basic eligibility requirements. Applicants and recipients shall meet the basic eligibility requirements of U.S. citizenship or legal resident alien status, state residency, not residing in a public institution, and provision of social security number, as described in chapter 17-1714. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-13 Categorical requirements. Persons who are ineligible to participate in QUEST include the following groups of individuals.

(1) Persons who are age sixty-five or older.

(2) Persons who are blind or disabled according to the criteria employed by the Social Security Administration.

(3) Persons who are age eighteen but under age sixty-five, employed, and receive or are eligible to receive employer sponsored health care coverage through their employer.

(A) This provision applies to affected employed persons and not to their dependent family members.

(B) This provision does not apply to AFDC and GA recipients of financial assistance as described in section 17-1727-15.

(C) This provision shall apply regardless of a person's previous eligibility for coverage under QUEST, prior to the implementation of this provision.

(4) An applicant under age nineteen, whose financial eligibility is established under section 17-1727-14(f), and is covered by a medical plan or has been uninsured for less than the entire three consecutive months immediately preceding the month in which eligibility for medical assistance is determined. For the purposes of this paragraph, "uninsured" means not covered by a medical plan, which includes but is not limited to, QUEST-Net coverage. This provision does not apply to a child whose health coverage:

(A) Is terminated due to loss of employment of a parent subscriber;

(B) In a group health plan is extended as a result of loss of employment of a parent subscriber and such coverage is terminated;

(C) Is terminated due to termination of a parent subscriber’s employee health benefits as a result of a long-term disability; and

(D) Is terminated when a parent subscriber is no longer eligible for employer sponsored health care coverage through

the employer as a result of becoming under-employed. For the purposes of this subparagraph, "under-employed" means working less than the minimum twenty hours per week that requires an employer to provide health care coverage to an employee as required by the Hawaii Prepaid Health Care Act. [Eff 08/1/94; am 07/20/95; am 01/29/96; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25; Pub. L. No. 105-33)

§17-1727-14 Financial eligibility requirements. (a) Assets shall be evaluated in the determination of financial eligibility for participation in QUEST in the following manner:

(1) Assets shall be evaluated for an individual or family, with the exception of a pregnant woman and a child under the age of nineteen;

(2) An individual or family subject to the asset determination, whose total countable assets as determined in chapter 17-1725 exceed the personal reserve standard of the QUEST program, shall be ineligible for QUEST; and

(3) The following personal reserve standard shall apply:

(A) For an individual or a couple applying for or receiving assistance the standard shall be equal to the standard employed by the SSI program.

(B) For each additional family member, $250 shall be added to the SSI personal reserve standard for a couple. The resultant amount is the standard for the family.

(b) An individual or family whose monthly countable family income does not exceed the following income limits shall be financially eligible for participation in QUEST:

(1) The income limit for a pregnant woman is one hundred eighty-five per cent of the federal poverty level for a family size which includes the number of unborn children expected;

(2) The income limit for an infant under one year of age is one hundred eighty-five per cent of

the federal poverty level for a family of applicable size;

(3) The income limit for a child age one but under age six is one hundred thirty-three per cent of the federal poverty level for a family of applicable size; and

(4) The income limit for all other individuals is one hundred per cent of the federal poverty level for a family of applicable size.

(c) A woman whose eligibility is established, under the provisions of subsection (b)(1), shall retain her eligibility for a sixty-day period following childbirth until the end of the month in which the sixty-day period ends. The woman's eligibility shall be redetermined for the first month following the month in which the sixty-day period ends.

(d) For a newborn who is added to a QUEST recipient household, under the provisions of chapter 17-1711-16(a), enrollment shall continue for a sixty-day period following the birth of the newborn until the end of the month in which the sixty-day period ends provided the newborn continues to be a member of the newborn's mother's household during the sixty-day period. The newborn's eligibility shall be determined for the first month following the month in which the sixty-day period ends.

(e) Eligibility shall be redetermined for the first month following the month in which a child will attain the maximum age, for a child whose eligibility is established under the provisions of subsection (b)(2) and (3).

(f) An uninsured applicant under age nineteen, whose monthly countable income exceeds the appropriate income limit under the provisions of subsection (b), but does not exceed two hundred percent of the federal poverty level for a family of applicable size shall be financially eligible for participation in QUEST. This provision shall not apply to a recipient.

(g) For an applicant, eligibility for medical assistance in QUEST-Spenddown shall be determined when one of the following conditions is met:

(1) The applicant's monthly countable income exceeds the appropriate income limit under the provisions of subsections (b) or (f); or

(2) The applicant meets the provision of section 17-1727-13(4).

(h) For a recipient, eligibility for medical assistance in QUEST-Net or QUEST-Spenddown shall be

determined when monthly countable income exceeds the appropriate income limit.

(i) The countable family income shall be determined in the following manner:

(1) For a pregnant woman and a child under nineteen years old who is born after September 30, 1983:

(A) Subtract a standard deduction of ninety dollars from the monthly gross earned income of each employed individual; and

(B) Add the monthly net earned income for each employed individual as well as any monthly unearned income to determine the countable family income.

(2) For all other family members, add the monthly gross earned income of each employed person and any monthly unearned income.

(j) The provisions of chapter 17-1724 shall be used to determine non-exempt income.

(k) When determining the financial eligibility of applicants for a specific calendar month, the applicants' total countable family income for that month shall be used, regardless of the date of application.

(l) A prospective budgeting method employing the department's best estimate of family size, income, and any other relevant factor shall be used in determining continued eligibility for participation in QUEST.

(m) When determining the premium-share for applicants or recipients of QUEST-related programs, the total countable family income for a month shall be rounded down to the next lower whole dollar and compared to the federal poverty level. [Eff 08/01/94; am 01/29/96; am 03/30/96; am 12/27/97; am 07/06/99; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25; Pub. L. No. 105-33)

§17-1727-14.1 Special provisions for individuals who are claimed as federal or state tax dependents. (a) The provisions of this section shall apply to an individual age eighteen but less than age twenty-one who is claimed as a federal or state tax dependent.

(b) In situations in which the individual claimed as a tax dependent is residing in the household with a parent or legal guardian who is claiming the individual as a tax dependent, the income and needs of the entire family, as defined in section 17-1727-2, shall be used

to determine the tax dependent's eligibility and premium-share to be assessed.

(c) In situations in which the individual claimed as a tax dependent does not reside in the household of a parent or legal guardian who is claiming the tax dependent, the tax dependent's total countable income shall be determined in the following manner:

(1) Determine the tax dependent's gross monthly income according to the provisions of chapter 17-1724.

(2) Determine the amount of support attributable to the tax dependent from the parent or legal guardian who is claiming the tax dependent as follows:

(A) Determine the gross monthly income of the parent or legal guardian who is claiming the tax dependent according to the provisions of chapter 17-1724.

(B) Subtract the amount equal to three hundred per cent of the federal poverty level for a family size equal to the number of individuals in the family of the parent or legal guardian who is claiming the tax dependent, excluding the tax dependent for whom eligibility is being determined.

(C) The remaining income is used as the support attributable to the tax dependent.

(3) Add the tax dependent's gross income and the support attributable to the tax dependent to arrive at the tax dependent's total countable income.

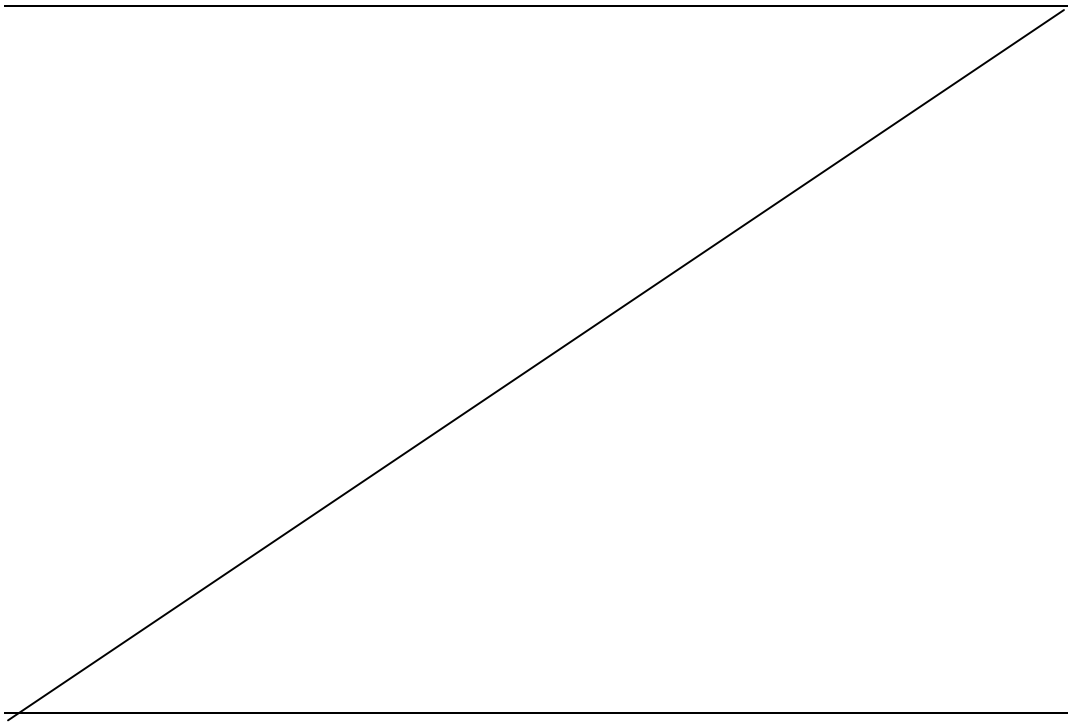
(4) The tax dependent's total countable income shall be used to determine eligibility for a QUEST-related program, and any assessment of and any assessment of premium-share for QUEST-Net. [Eff 07/20/95; am 01/29/96; am 12/27/97; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

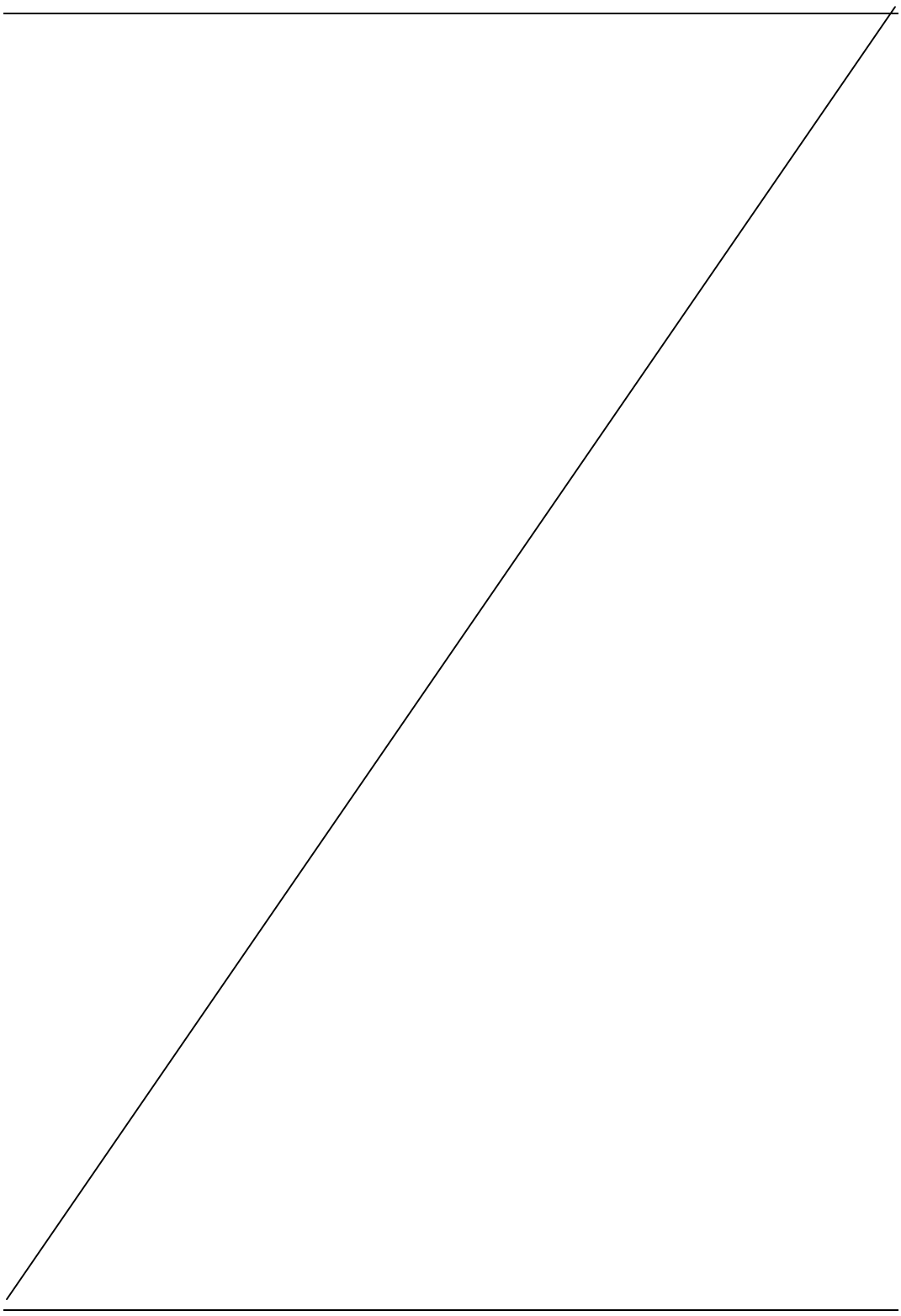
§17-1727-15 Eligibility for AFDC and GA financial assistance recipients. (a) Individuals who are recipients of financial assistance under the AFDC and GA programs shall be eligible for participation in QUEST if all categorical requirements specified in this subchapter are met.

(b) An AFDC or GA financial assistance recipient who is age sixty-five or older or who is blind or disabled according to criteria employed by the Social Security Administration shall be ineligible to participate in QUEST. Such an individual may receive medical assistance through the department's fee-for-service program. [Eff 08/01/94; am 01/29/96; am 02/10/97] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-16 Special provisions for individuals with family incomes in excess of three hundred per cent of the federal poverty level on July 31, 1994 and who are eligible for medical assistance on a spend-down basis. (a) Individuals, whose family incomes exceed three hundred per cent of the federal poverty level, who are otherwise eligible for coverage under QUEST, and who are eligible for medical assistance on a spend-down basis on July 31, 1994, may be allowed to participate in QUEST.

(b) The individuals described in subsection (a) shall be eligible for coverage under QUEST if they assume financial responsibility for the lessor of one





hundred percent of the capitated rate for the plan in which they are enrolled or the dollar amount that the individuals were required to spend-down for the month of July 1994. [Eff 08/01/94; am 01/29/96] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-17 Eligibility for individuals eligible under Title IV-E. (a) The following individuals shall be automatically eligible for medical assistance:

(1) Individuals receiving Title IV-E foster care maintenance payments, who are:
    (A) Under twenty-one years of age;
    (B) Certified by a social worker of the department to be eligible for Title IV-E foster care maintenance payments; and
    (C) Placed in a licensed or authorized foster home or child caring institution appropriately supervised by a licensed child placement agency or the state family court; or
(2) Individuals covered under Title IV-E Adoption Assistance Agreements, regardless of the state with which the adoptive parents entered into the agreement, who are:
    (A) Under twenty-one years of age;
    (B) Reside in the State of Hawaii; and
    (C) Reside in a subsidized adoptive home.

(b) The continued eligibility of these individuals to receive medical assistance shall be contingent upon their eligibility for coverage under Title IV-E.

(c) These individuals shall be ineligible to receive medical assistance as specified in this section when they are no longer eligible for coverage under Title IV-E.

(d) Individuals eligible for coverage under Title IV-E who are not blind or disabled shall be provided coverage in QUEST.

(e) Individuals eligible for coverage under Title IV-E who are blind or disabled shall be provided medical coverage on a fee-for-service basis.

(f) Upon determination of their ineligibility for coverage under Title IV-E, eligibility for continued medical assistance shall be determined in the following manner:

(1) Eligibility and participation in QUEST if all conditions of this chapter are met; or
(2) Eligibility and participation in the blind or disabled programs if all conditions of both programs are met. [Eff 11/25/96] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1727-18 to 17-1727-20 (Reserved).

SUBCHAPTER 4

ENROLLMENT

§17-1727-21 Enrollment of individuals into participating health plans. (a) Each individual found eligible to participate in QUEST shall be enrolled in both a medical and a dental plan with the exception of children identified in subsection (b).

(b) After being found eligible for the QUEST, fee for service coverage shall be provided for children under age twenty-one who meet all of the following conditions:

(1) Receive child welfare services from the department of human services or court;
(2) Are residents of the State of Hawaii; and
(3) Are placed in another state.

Children meeting the above conditions shall not be enrolled in a QUEST medical or dental plan.

(c) All eligible family members living in the same household shall be enrolled in the same participating health plans. [Eff 08/01/94; am 01/29/96] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-22 Initial enrollment. (a) After being found eligible for coverage under QUEST, an individual shall be allowed ten days to select from among the participating health plans available in the area in which the individual resides.

(b) If an individual does not select a medical or dental plan within ten days of being determined eligible, enrollment in a health plan shall be assigned by the department.

(c) An enrollee shall only be allowed to change enrollment from one medical or dental plan to another during the annual open enrollment period.

(1) The exceptions to the preceding provision include decisions from administrative hearing, legal decisions, termination of plan contract, or mutual agreement by the health plans involved, the enrollee, and the department.

(2) Reasons for the preceding exceptions include efforts to enroll reconciled or newly formed families into the same plan, change in residences by an enrollee from geographic area serviced by one plan to that serviced by a different plan or plans, change in foster placement if necessary for the best interest of the child, and other special circumstances.

(d) An individual who is disenrolled from a QUEST health plan shall be allowed to select a plan of their choice if disenrollment extends for three or more consecutive calendar months in a benefit year. [Eff 08/01/94; am 01/29/96; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 431.51)

§17-1727-23 Open enrollment period. (a) An eligible individual or family shall be allowed to change the individual's or family's enrollment from one medical or dental plan to another participating plan within the service area in which the individual or family resides during the annual open enrollment period.

(b) The open enrollment period shall occur in May of each calendar year.

(c) A recipient who is enrolled in a non-returning plan shall be allowed to select from the available plans.

(d) If the recipient is required to select a plan, but does not select a plan during the open enrollment period, enrollment in a health plan shall be assigned by the department.

(e) Changes in enrollment resulting from an open enrollment period shall be implemented effective the first day of July of that calendar year and shall generally extend to June 30 of the following calendar year. [Eff 08/01/94; am 06/19/00] (Auth: HRS

§346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 431.51)

17-1727-24 Effective date of enrollment. (a) For applicants newly approved for coverage, the effective date of enrollment shall be one of the following:

(1) The date the enrollment process has been completed to enroll an individual or family in a QUEST health plan.

(2) If the applicant is found to be ineligible for the month of application, the date of the subsequent month in which all eligibility requirements are met by the applicant.

(b) The effective date of enrollment resulting from a change from one plan to another during the annual open enrollment period shall be the first day of July of that calendar year.

(c) The effective date of enrollment resulting from a change from one plan to another, other than during the open enrollment period, shall be the first day of the month following the date on which the State authorizes the enrollment change.

(d) The effective date of enrollment for a newborn of a recipient shall be the child's date of birth. The newborn shall be ineligible for continued enrollment if an application for medical assistance is not submitted in a timely manner. [Eff 8/01/94; am 07/20/95; am 01/29/96] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 431.51)

§17-1727-25 Coverage of QUEST eligibles prior to the date of enrollment. (a) An applicant who is initially determined eligible under QUEST shall be eligible for coverage of health care costs by the department on a fee for service basis as of the date of coverage through the date of enrollment.

(b) The date of coverage shall be one of the following:

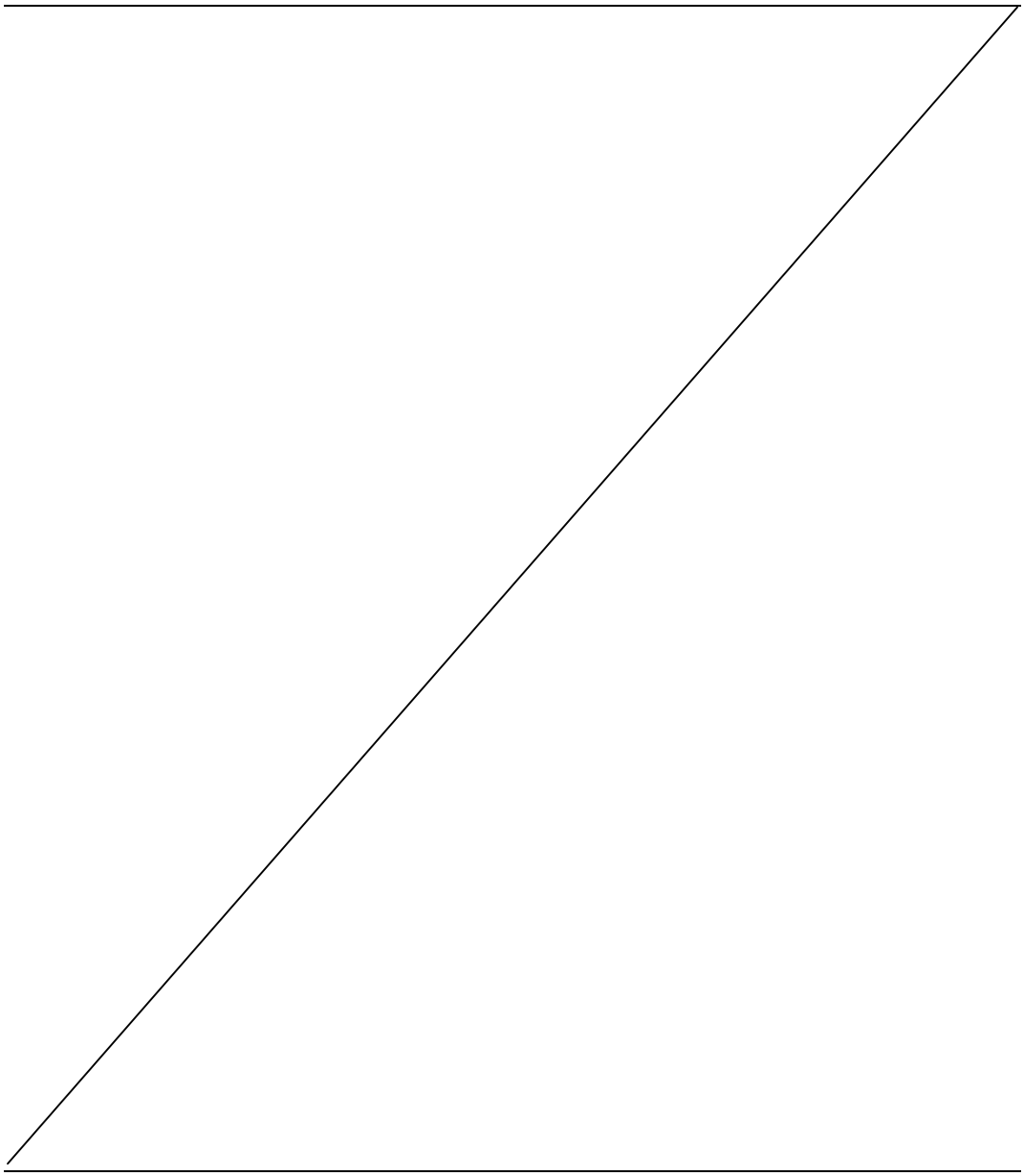
(1) The date of application;

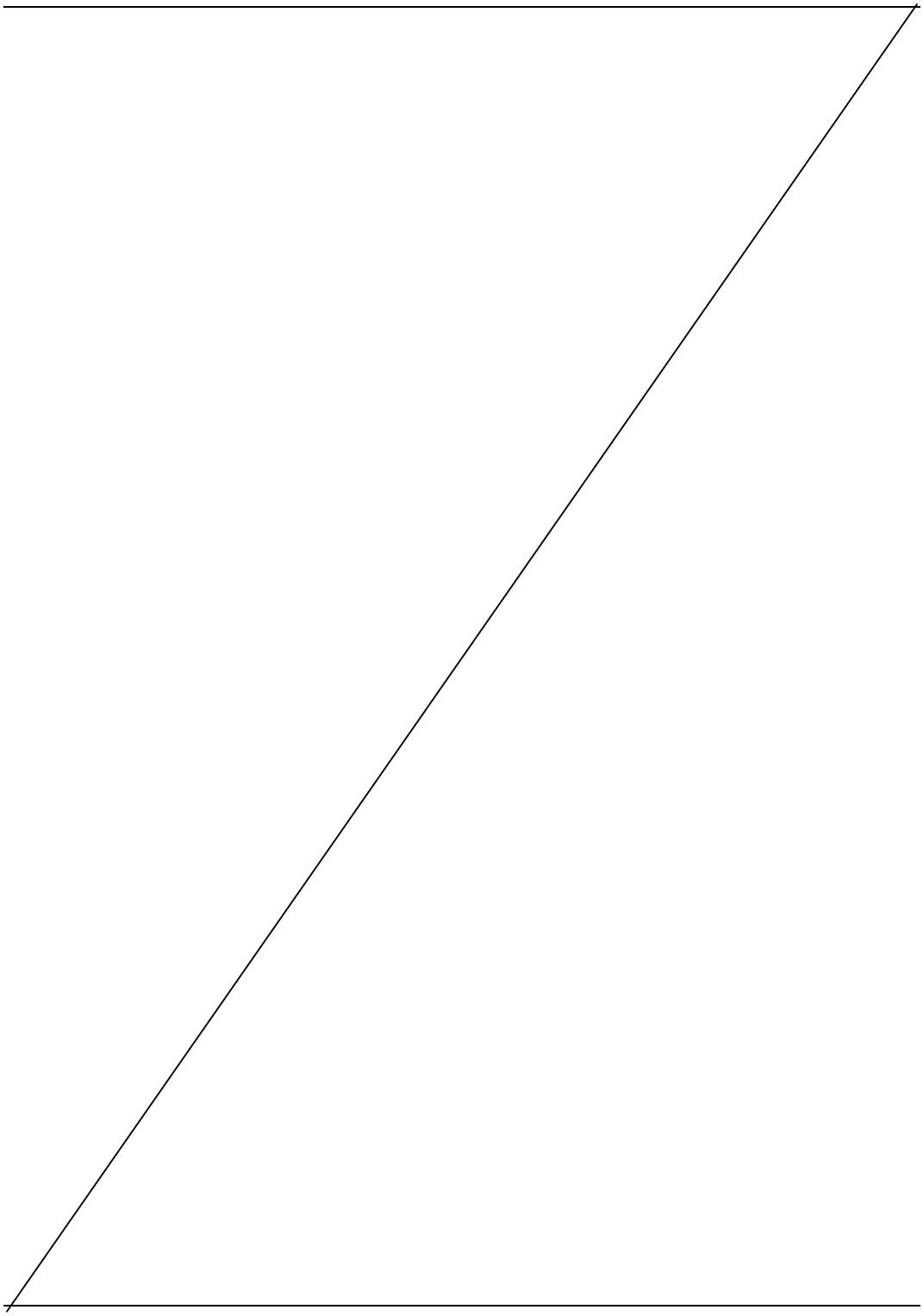
(2) If specified by the applicant, any date on which appropriate emergency room or hospital expenses were incurred and which is within the immediate five calendar days prior to the date of application; or

(3) If the application is found to be ineligible for the month of application, the date of the

subsequent month on which all eligibility requirements are met by the applicant.

(c) The provisions of the fee for service program as described in chapter 17-1735, 17-1736, and 17-1737 shall apply from the date of eligibility to the date of enrollment for those who are initially determined eligible for QUEST. [Eff 07/20/95] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)





§17-1727-26 Limitations of statewide enrollment in participating health plans. (a) The maximum statewide enrollment in the QUEST medical plans shall be 125,000 enrollees.

(b) The department shall not accept applications for QUEST coverage when the statewide enrollment as of the last day of the previous calendar year exceeds the maximum allowed by this section.

(c) The department shall accept applications for QUEST coverage during an open application period to be announced by the department as described in sections 17-1711-2 and 17-1711-3.

(d) The following individuals are exempt from this provision and shall be enrolled in a participating health plan if determined eligible for QUEST:

(1) AFDC or GA financial assistance recipients;

(2) Individuals whose countable income does not exceed the AFDC standard of assistance;

(3) Pregnant women whose countable family income does not exceed one hundred eighty-five per cent of the federal poverty level for a family size which includes the number of unborn children expected;

(4) Children under the age of nineteen, whose countable family income does not exceed two hundred per cent of the federal poverty level;

(5) Individuals whose coverage in an employer sponsored health plan is terminated due to loss of employment which occurred within forty-five calendar days of the date of application for medical assistance;

(6) Individuals whose health coverage in a group health plan is extended as a result of loss of employment and such coverage ends within forty-five calendar days of the date of application for medical assistance; and

(7) Children under age twenty-one years of age who receive child welfare services, to include children in foster care and children covered by adoption assistance agreements.

[Eff 01/29/96; am 03/30/96; am 11/25/96; am 12/27/97; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 431.51)

§17-1727-27 (Reserved).

SUBCHAPTER 5

DISENROLLMENT

§17-1727-28 Authority to disenroll QUEST beneficiaries. (a) DHS shall have sole authority to disenroll an individual from a QUEST Plan.

(b) A health plan may recommend disenrollment of an individual from QUEST health plans, when appropriate.

(c) DHS shall consider disenrollment of an individual from a QUEST health plan in compliance with administrative appeal decisions or court orders, in response to mutual agreements among enrollees, the plans, and the Department, and when requested by participating health plans for enrollees who are abusive or noncompliant. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-29 Requests from health plans for disenrollment. (a) A health plan may request disenrollment for reasons including, but not limited to:

(1) Chronic refusal by an enrollee to pay the plan for the required service specific co-payments described in this chapter;

(2) Chronic abusive behavior on the premises of a plan's providers, against the provider staff, other patients, or other individuals; or

(3) Chronic refusal to comply with a treatment plan.

(b) A plan shall ensure that the abusive or noncompliant enrollee is afforded sufficient opportunity to comply with the requirements of the plan and its providers and to correct the enrollee's behavior, prior to recommending disenrollment.

(c) A plan shall provide the enrollee sufficient opportunity to present the enrollee's case through the plan's grievance procedures, as specified in the contract between the plan and the State, prior to recommending disenrollment.

(d) Upon exhausting avenues of reconciliation of problems with an abusive or noncompliant enrollee, a plan may submit a recommendation for disenrollment to the Department.

(e) A plan shall provide the enrollee adequate advance notice of the plan's intent to recommend disenrollment. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-30 Disenrollment of enrollees from QUEST plan. An individual or family may be disenrolled for reasons, which include, but are not limited to, the following:

(1) Failure to pay the individual's or family's total designated premium-share for QUEST or QUEST-Net coverage;

(2) The department's concurrence with a participating plan's recommendation for disenrollment of an individual who is chronically abusive or noncompliant;

(3) A mutual agreement among an individual or family, the participating plans involved, and the department; or

(4) A voluntary withdrawal from participation in QUEST by an individual or family.

[Eff 08/01/94; am 01/29/96; am 11/25/96; am 12/27/97] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-31 Special provisions for certain individuals disenrolled from QUEST plans. (a) An individual who is disenrolled from a participating health plan due to chronic abusive behavior or chronic refusal to comply with a treatment plan shall be provided membership in a health plan contracted by the State to provide basic health care coverage, providing the individual:

(1) Has family income which does not exceed one hundred thirty-three per cent of the federal poverty level for a family of applicable size, or if such individual is pregnant, has

family income which does not exceed one hundred eighty-five per cent of the federal poverty level for a family of applicable size;

(2) Meets all other eligibility requirements for participation in QUEST; and

(3) Requests enrollment in the health plan.

(b) Basic health care coverage provided by the plan described above shall include, but may not be limited to:

(1) Acute inpatient hospital care, limited to five days in a benefit year;

(2) Medical and surgical services which are considered medically necessary;

(3) Physicians' office visits including diagnosis, treatment, and consultation shall be limited to twelve visits within a benefit year;

(4) Prenatal and maternity care, which are not included in the twelve visits limitation for physicians' office visits;

(5) Adult health appraisals, including services and test, which shall be limited to once each benefit year; and

(6) Emergency room services for medical conditions manifesting themselves by acute symptoms of such severity that the absence of medical attention could reasonably be expected to result in placing the patient's health in severe jeopardy or severe impairment to bodily functions, or serious dysfunction of any body organ or part.

(c) Exclusions from coverage by this plan include, but are not limited to:

(1) Services which are not medically necessary;

(2) Custodial and domiciliary care, skilled nursing care, and intermediate care facilities;

(3) Emergency room services for non-emergency conditions;

(4) Health services or items for reasons, including but not limited to the following:

(A) The procedure, service, or material is of generally unproven benefit;

(B) It is of experimental nature;

(C) It is excluded in the department's medical assistance program by federal regulations or state rules; or

(D) It is not considered medically necessary by the plan;

(5) Dental services and services for temporomandibular joint problems, except for repair necessitated by accidental injury to sound natural teeth or jaw, if the individual was a member of the plan at the time the accident occurred and such repair is initiated within ninety days of the accident;

(6) Prescription and non-prescription drugs and hormones and their administration, except those medically necessary and provided as part of inpatient hospital services;

(7) Visual services, including, but not limited to, eye examinations, refractions, vision analysis, eyeglasses, contact lenses, and related services;

(8) Services, supplies, and equipment for speech, hearing and language disorders which include diagnostic, screening, preventive, or corrective services provided by or under direction of a speech pathologist or audiologist;

(9) Orthopedic services and supplies;

(10) Acupuncture;

(11) Biofeedback;

(12) Purchase or rental of durable medical equipment, including but not limited to hospital beds, wheel chairs, walk-aids; or other medical equipment and supplies not specifically listed as covered services, except as part of inpatient hospital services;

(13) Cosmetic surgery and reconstructive surgery for congenital or acquired conditions that do not involve severe functional impairment.

(14) Transportation;

(15) Medical services rendered outside the State of Hawaii;

(16) Outreach services;

(17) Conditions resulting from acts of war; and

(18) Any service, equipment, or item not included in the benefits provided by QUEST. [Eff 08/01/94; am 01/29/96] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1727-32 to 17-1727-34 (Reserved).

SUBCHAPTER 6

REIMBURSEMENT TO PARTICIPATING PLANS

§17-1727-35 Capitated payments. (a) Each participating plan shall be paid on a capitated basis, as negotiated with the Department, for individuals enrolled in that plan.

(b) The Department shall provide the capitated payment, as stipulated in the contract between the Department and each participating plan, in return for the plan's provision of all negotiated services for the plan's enrollees. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-36 REPEALED. [Eff 08/01/94; R 07/20/95] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1727-37 to 17-1727-39 (Reserved).

SUBCHAPTER 7

FINANCIAL RESPONSIBILITIES OF QUEST ENROLLEES

§17-1727-40 Premium-share. (a) An enrollee may be assessed responsibility for payment of the monthly capitated rate which is paid by the department for the enrollee's coverage. The capitated rate, including that of catastrophic coverage, for which an enrollee may be responsible is known as the premium-share.

(b) An enrollee who is assessed a premium-share shall pay that amount to the department by the tenth day of the benefit month.

(c) The department shall initiate disenrollment procedures for an enrollee whose premium-share payments are two months in arrears.

(d) An individual eligible for medical assistance only coverage in QUEST, with the exception of individuals identified in subsection (e) of this section, shall be required to satisfy all outstanding

premium-share debts, to the department's satisfaction, prior to being allowed to participate in QUEST.

(e) The following individuals, who are exempt from the maximum enrollment provisions, shall be exempt from the provision to satisfy premium-share debts prior to being allowed to participate in QUEST:

(1) AFDC or GA financial assistance recipients;

(2) Individuals whose countable income does not exceed the AFDC standard of assistance;

(3) Pregnant women whose countable family income does not exceed one hundred eighty-five per cent of the federal poverty level for a family size which includes the number of unborn children expected;

(4) Children under the age of nineteen, whose countable family income does not exceed two hundred per cent of the federal poverty level;

(5) Individuals whose coverage in an employer sponsored health plan is terminated due to loss of employment which occurred within forty-five calendar days of the date of application for medical assistance;

(6) Individuals whose health coverage in a group health plan is extended as a result of loss of employment and such coverage ends within forty-five calendar days of the date of application for medical assistance; and

(7) Children under age twenty-one years of age who are eligible for foster care maintenance payments or adoption subsidy payments.

[Eff 08/01/94; am 01/29/96; am 03/30/96; am 02/10/97; am 12/27/97; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-41 REPEALED. [Eff 08/01/94; am 07/20/95; R 12/27/97]

§17-1727-42 Enrollees with premium-shares. (a) An adult enrollee who is self-employed or is the spouse of a self-employed adult in the family, with the exception of an enrollee who is pregnant or who is an AFDC or GA financial assistance recipient, shall be responsible for fifty per cent of the premium-share if the countable family income is equal to or less than

one hundred per cent of the federal poverty limit for a family of appropriate size.

(b) A maximum of five enrollees in a family shall be assessed a premium-share for QUEST or QUEST-Net coverage by the department in the following manner:

(1) Determine the number of persons in a family eligible for QUEST or QUEST-Net coverage who are responsible for a premium-share; and

(2) Assess premium-shares to a maximum of five enrollees in descending order by date of birth. [Eff 08/01/94; am 07/20/95; am 01/29/96; am 03/30/96; am 11/25/96; am 12/27/97] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-43 Co-payments. (a) Certain enrollees shall be required to pay specified dollar amounts, known as co-payments, for certain kinds of services.

(b) The co-payment amounts and the services for which the co-payments are required are described in the Co-Payments Table dated April 2000 located at the end of this chapter. [Eff 08/01/94; am 03/30/96; am 11/25/96; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-44 REPEALED. [Eff 08/01/94; am 07/20/95; am 01/29/96; R 12/27/97]

§17-1727-45 Enrollees responsible for co-payments. An enrollee age twenty-one or older who is responsible for a premium-share will be responsible for all co-payments. [Eff 01/29/96; am 12/27/97; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1727-46 and 17-1727-47 (Reserved).

SUBCHAPTER 8

SCOPE AND CONTENT OF SERVICES

§17-1727-48 Standard Benefits Package. (a) Each of the participating plans shall be required to provide certain benefits as defined in the contract between the plans and the Department.

(1) Participating medical plans shall provide all required basic medical services, as defined in the contract with the Department.

(2) Participating dental plans shall provide all required dental services as defined in the contract with the Department.

(3) Participating behavioral health managed care plans who contract with the Department to treat individuals who are diagnosed by an independent clinical evaluator as suffering from severe disabling mental illness, shall provide the services defined in the contract with the Department.

(b) The benefits minimally required of each of the participating plans shall be known as the standard benefits package.

(c) A participating plan may, at the plan's option, provide benefits which exceed the requirements of the standard benefits package. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-49 Basic medical services to be provided by participating plans. (a) Participating medical plans shall provide all medical services that are required by medicaid.

(b) There shall be a one-month waiting period for all non-urgent and non-emergent medically necessary services as determined by the department or the participating health plan. This provision does not apply to an enrollee below the age of twenty-one.

(c) Participating medical plans shall provide preventive, diagnostic, and medically necessary services which include, but are not limited to, the following:

(1) Inpatient hospital services for medical, surgical, rehabilitative, maternity, and newborn care, including room and board, nursing care, medical supplies, equipment, drugs, diagnostic services, physical and

occupational therapy, speech and language therapy, and other medically necessary services;

(2) Outpatient hospital services, including emergency room services, ambulatory surgery, urgent care services, medical supplies and equipment, drugs, diagnostic services, therapeutic services such as chemotherapy and radiation therapy, and other medically necessary services;

(3) Preventive services, including initial and interval histories, physical examinations and developmental assessments, immunizations, family planning services, diagnostic and screening laboratory and radiology services including screening for tuberculosis;

(4) Prescribed drugs, blood, and blood products;

(5) Radiology, laboratory, and other diagnostic services including imaging, screening mammograms, screening and diagnostic laboratory tests, therapeutic radiology, and other medically necessary diagnostic services;

(6) Physician services, including services of psychiatrists;

(7) Maternity services such as prenatal care and laboratory screening tests, treatment of missed, threatened, incomplete and elective abortions, delivery of infants, and postpartum care;

(8) Other practitioner services including podiatrists, optometrists, psychologists, nurse midwives, pediatric nurse practitioners, family nurse practitioners, and other practitioner services needed to provide medical care;

(9) Therapeutic services including physical therapy, occupational therapy, speech therapy, and audiology services, and other medically necessary therapeutic services;

(10) Durable medical equipment, prosthetic devices, orthotics, and medical supplies including, but not limited to, oxygen tanks, oxygen concentrators, eyeglasses, ventilators, wheelchairs, crutches, canes, braces, hearing aids, pacemakers, and other

medically necessary appliances, supplies, and artificial aids;
(11) Home health services including skilled nursing, home health aides, therapeutic services, medical supplies and equipment, and other medically necessary home health services;
(12) Hospice services;
(13) Organ and tissue transplant services, including cornea, kidney, allogenic and bone marrow;
(14) Transportation services;
(15) Sterilizations;
(16) Hysterectomies;
(17) Services federally mandated by the Early and Periodic Diagnosis, Screening, and Treatment program; and
(18) Behavioral health services including preventive, diagnostic, therapeutic, and rehabilitative services for mental health problems, drug abuse, and substance abuse, with limitations as specified in section 17-1727-49.1; and
(19) Out-of-state services. [Eff 08/01/94; am 01/29/96; am 03/30/96; am 11/25/96; am 02/10/97; am 12/27/97; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-49.1 Limitations to behavioral health benefits. (a) Behavioral health benefits provided through participating medical plans are limited as follows:
(1) Twenty-four hours of outpatient visits and thirty days of hospitalization per benefit year. Outpatient hours or inpatient days not used in a benefit year shall not be added to the benefits of the following year;
(2) The diagnosis and treatment of substance abuse shall be included in the inpatient and outpatient benefits for psychiatric treatment. Each day of inpatient hospital services may be exchanged for two days of non-hospital residential services, two days of partial hospitalization services, or two days of day treatment or two days intensive outpatient services. Detoxification, whether provided in a hospital or in a non-hospital

facility, shall be considered as a part of the inpatient benefit limit.

(b) A participating plan may, at the plan's option, exceed the limits on behavioral health services.

(c) For an enrollee below the age of twenty-one, the plan may exceed the limits for medically necessary services to be in compliance with EPSDT requirements. [Eff 03/30/96; am 12/27/97; am 06/19/00] (Auth: HRS §346-14) (Imp: 42 C.F.R. §430.25)

§17-1727-50 Dental services to be provided by participating plans. (a) Participating dental plans shall provide all required preventative dental services and all medically necessary dental services to an enrollee under the age twenty-one. Services shall include, but are not limited to, the following:

(1) Diagnostic and preventative services provided once every six months;

(2) Non-emergency care including endodontic therapy, periodontic therapy, restoration, and prosthodontic services;

(3) Emergency treatment which includes services to relieve dental pain, eliminate infection, and treatment of acute injuries to the teeth and supporting structures of the oro-facial complex; and

(4) EPSDT services shall be provided routinely beginning at twelve months of age; however, EPSDT services are allowable as early as six months of age at the discretion of the participating dentist.

(b) All dental services required under the federally mandated Early and Periodic Screening, Diagnosis, and Treatment program for an enrollee under the age of twenty-one shall be provided by the participating dental plans.

(c) An enrollee age twenty-one or older who is eligible for QUEST shall only have coverage for emergency dental services which do not include services aimed at restoring and replacing teeth and shall include services for the following:

(1) Relief of dental pain;

(2) Elimination of infection; and

(3) Treatment of acute injuries to the teeth or supporting structures of the oro-facial complex. [Eff 08/01/94; am 01/29/96; am 03/30/96; am 11/25/96; am 06/19/00]

(Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-51 Behavioral health services for individuals with serious and persistent mental illness. (a) Individuals who are certified by an independent clinical evaluator as suffering from serious and persistent mental illness shall be eligible for enrollment in a behavioral health managed care plan contracted by the Department to treat these individuals.

(b) Upon an individual's enrollment in a behavioral health managed care plan, the basic medical plan in which the individual is enrolled shall no longer be responsible to provide behavioral health services for that individual. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-52 REPEALED. [Eff 08/01/94; R 12/27/97]

§§17-1727-53 to 17-1727-57 (Reserved).

SUBCHAPTER 9

PARTICIPATING HEALTH PLANS

§17-1727-58 Health plan participation in QUEST. (a) The Department shall request proposals from managed health care plans for provision of medical, dental, or behavioral health services to persons eligible to participate in QUEST.

(b) The Department shall evaluate the proposals from managed care plans to ensure that the plans meet the conditions and requirements described in the Department's request for proposals.

(c) Contracts for participation in QUEST shall be awarded to qualified health plans upon finalization of financial agreements with the Department.

(d) The Department shall develop a request for proposals prior to the lapse of existing contracts with participating plans to ensure that individuals eligible

for coverage through QUEST shall receive continued health care coverage. [Eff 08/01/94; am 01/29/96] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-59 Service areas. (a) The Department shall designate geographic areas as the areas for which health care plans will submit proposals to provide services.

(b) A health plan may submit proposals to service more than one service area.

(c) More than one health care plan may be contracted by the Department for each service area. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-60 Requirements of participating plans. (a) The plans participating in QUEST shall abide by the provisions of their respective contracts with the Department.

(b) The requirements of each participating plan shall include, but are not limited to, the following:

(1) Provision of all services required by the contract between the respective plan and the Department;
(2) Provision of a primary care provider for each eligible QUEST recipient who is enrolled in the in the respective plan;
(3) Provision of a case management system to ensure that health services identified by an enrollee's personal care provider as medically necessary are received;
(4) Development and maintenance of a sufficient network of health care providers to ensure that required health services are provided to enrollees in a timely manner;
(5) Maintenance of adequate support staff and systems to administer and conduct business functions;
(6) Development and maintenance of required information systems;
(7) Development and maintenance of a quality assurance program;
(8) Development and maintenance of a grievance system for dissatisfied enrollees;
(9) Development and maintenance of a toll-free telephone hotline to confirm enrollment, respond to inquiries from enrollees, and

provide information to the general public; and

(10) Maintenance of a medical records systems which enable the plans to provide information pertinent to the care and management of enrollees to the Department.

[Eff 08/01/94; am 01/29/96] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-61 Enforcement of contracts with participating health plan. (a) The department may monitor a health plan's performance during any contract period.

(b) The department may impose civil or administrative monetary penalties not to exceed the maximum amount established by federal and state statutes and regulations if the participating health plan:

(1) Fails to provide medically necessary items and services that are required under law or under contract;

(2) Imposes upon beneficiaries excess premiums and charges;

(3) Acts to discriminate among enrollees;

(4) Misrepresents or falsifies information;

(5) Violates marketing guidelines established by the department; or

(6) Violates other contract provisions and requirements.

(c) The department may appoint temporary management to oversee compliance efforts if a health plan continues to violate the contract conditions between the health plan and the department, violates federal and state statutes, violates the Hawaii Administrative Rules, or if there is a substantial risk to the health of enrollees.

(d) The department shall notify the insurance commissioner whenever a sanction under this section is contemplated specifying the reason.

[Eff 06/19/00] (Auth: SLH 1998, Act 94) (Imp: HRS 346-14; 42 C.F.R. 430.25)